

Role of mRNA Expression of Transcription Factors in Glucocorticoid Sensitivity of Peripheral Blood Mononuclear Cells and Disease State in Rheumatoid Arthritis

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ABSTRACT. Objective. To investigate the mechanisms underlying glucocorticoid (GC) resistance in rheumatoid arthritis (RA), we evaluated the suppressive effects of prednisolone (PSL) or methylprednisolone (MPSL) on the blastogenesis of peripheral blood mononuclear cells (PBMC). We also measured the expression of mRNA for transcription factors [GC receptor- α (GR α) and activator protein-1] known to be involved in the exertion of GC effects.

Methods. Twenty-six patients with RA and 17 healthy subjects were studied. IC₅₀ of PSL and MPSL on the blastogenesis of PBMC stimulated with concanavalin A *in vitro* was estimated. Transcripts for GR α , c-fos, c-jun, and GAPDH genes in PBMC were quantitatively determined by real-time RT-PCR procedures.

Results. The amount of c-fos transcript in PBMC from RA patients was significantly high compared to the healthy subjects ($p = 0.001$). However, no difference was found in the amounts of mRNA of other transcription factors between the patients and healthy subjects. When PSL or MPSL IC₅₀ in patients were directly correlated with patients' characteristics in RA, the duration of disease showed a significant positive correlation with PSL IC₅₀ ($p = 0.035$). However, no significant association of PSL or MPSL IC₅₀ with GR α , c-fos, or c-jun mRNA expression determined by RT-PCR was observed. Additionally, there were significant correlations between the amount of GR α mRNA and inflammatory indices such as erythrocyte sedimentation rate ($p < 0.001$) and C-reactive protein ($p < 0.05$) in the RA patients.

Conclusion. Chronic exposure to inflammation in RA suggests a decrease in the GC sensitivity of peripheral lymphocytes. Although c-fos and GR α transcripts in PBMC have been implicated in the pathology of RA, the amount of expression of these factors may not be critical for the development of GC insensitivity in the PBMC in RA. (J Rheumatol 2004;31:464-9)

Key Indexing Terms:

TRANSCRIPTION FACTOR ACTIVATOR PROTEIN-1 HYDROCORTISONE
GLUCOCORTICOID RECEPTORS RHEUMATOID ARTHRITIS

For many years, glucocorticoids (GC) have been the cornerstone in the treatment of autoimmune or inflammatory diseases including rheumatoid arthritis (RA), ulcerative colitis, and bronchial asthma. There are, however, a proportion of patients with RA who do not benefit from GC

therapy. The individual lymphocyte responsiveness to GC determined by the mitogen proliferation assay has been reported to be useful to identify GC-insensitive patients before they undergo GC treatment¹⁻⁵.

It has been reported that the effect of GC is mainly mediated by their binding to GC receptor (GR α), a well investigated receptor isoform. GR α is categorized as a transcription factor in that it interacts with other transcription factors (trans-repression) and also regulates gene expression by binding the GC responsive element (GRE) (trans-activation)⁶. After binding with GC, GR α homodimerizes and binds to GRE located in the promoter region of genes encoding antiinflammatory mediators, and consequently trans-activates such gene expression. Meanwhile, GC-GR α complex interacts directly with other transcription factors such as activator protein-1 (AP-1) and nuclear factor- κ B (NF- κ B), and inhibits the induction of proinflammatory cytokine gene expression.

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AP-1, a heterodimer of Fos and Jun oncoproteins, binds to tetradecanoyl phorbol acetate-response element, which has been found in the promoters of genes encoding collagenase, matrix metalloproteinases, and interleukin 1 that are essential in the pathology in RA⁷. Indeed, it has been reported that c-fos expression and AP-1 DNA binding are constitutively upregulated in RA synovium⁸.

GC-GR α complex interacts with AP-1, and these transcription factors attenuate their effects mutually. Excessive AP-1 results in the deprivation of effective GR α complex, decreasing the amount of GR α that exerts the effect of transactivation. It has been observed that the expression of c-fos and DNA binding of AP-1, but not NF- κ B and cyclic AMP response element binding protein, is increased in GC-resistant asthmatic patients compared to GC-sensitive ones, suggesting that AP-1 also contributes to acquiring desensitization to GC^{9,10}.

Although the role of transcription factors such as AP-1 in the pathogenesis of RA has been described recently^{8,11}, to date the relationship between the expression amount or function of AP-1 and GC efficacy in RA has not been investigated. Since inflammatory cytokines and related molecules that play major roles in the pathogenesis of each autoimmune disease are different, the mechanism(s) for GC resistance in RA should be investigated. To determine the association of AP-1 and GR α with the efficacy of GC in RA, we investigated the relationship between the expression of mRNA for AP-1 or GR α and lymphocyte sensitivity to GC using a mitogen proliferation assay.

MATERIALS AND METHODS

Twenty-six Japanese patients diagnosed with RA and 17 healthy controls were studied (male/female: 5/21 for patients and 2/15 for controls). The mean age was 55.8 ± 13.6 years (range 28–82) in patients and 44.4 ± 9.8 years (range 31–66) in controls. No patient had complications of immunological disorders other than RA. At the time of blood sampling no patient had experience of GC administration, or alternatively had had a washout period of at least 3 months from the last GC treatment. Patients being administered methotrexate were excluded. Erythrocyte sedimentation rate (ESR), serum C-reactive protein (CRP) concentration, rheumatoid factor (RF), and the white blood cell (WBC) count at the time of blood sampling were also measured.

Isolation of PBMC. With patients' informed consent, venous blood was taken between 1:00 PM and 3:00 PM. The heparinized blood was loaded on Ficoll-Hypaque and centrifuged. PBMC, including lymphocytes, were separated as described^{12,13}.

PBMC culture and evaluation of drug effects. Two hundred microliters of cell suspension were placed into each of the 96 flat-bottom wells of a microtiter plate. Concanavalin A (ConA) as a mitogen was added to each well to a final concentration of 5.0 μ g/ml. Subsequently, 4 μ l of ethanol solution containing prednisolone (PSL) or methylprednisolone (MPSL) were added to yield final concentrations of 0.1, 1.0, 10, 100, 1000, and 10,000 ng/ml (corresponding to 2.8×10^{-10} , 10^{-9} , 10^{-8} , 10^{-7} , 10^{-6} , and 10^{-5} M PSL and 2.7×10^{-10} , 10^{-9} , 10^{-8} , 10^{-7} , 10^{-6} , and 10^{-5} M MPSL, respectively). Four microliters of ethanol were then added to the control wells. The plate was incubated 96 h in 5% CO₂/air at 37°C in a humidified chamber. The cells were pulsed with 18.5 kBq/well of [³H] thymidine for the last 16 h of incubation and then collected on glass-fiber filter paper using a multihar-

vester device and dried. The radioactivity retained on the filter was processed for liquid scintillation counting. The mean of the counts for duplicates of each sample was determined, and the agent concentration that would result in 50% lymphocyte-mitosis inhibition (IC₅₀) was determined from the dose response curves.

Extraction of RNA and quantitative real-time reverse transcription-polymerase chain reaction (RT-PCR). PolyA(+)RNA was isolated from patients' PBMC using a QuickPrep polyA(+)RNA extraction kit (Amersham Pharmacia Biotech, Buckinghamshire, UK) according to the manufacturer's instructions. cDNA was constructed by RT in 50 μ l buffer containing 1 \times TaqMan buffer, 5.5 mM MgCl₂, 500 μ M of each dNTP, 2.5 μ M of random hexamer, 0.4 U/ μ l of RNase inhibitor, and 1.25 U/ μ l of MultiScribe reverse transcriptase. RT was performed with a stepwise reaction at 25°C for 10 min, 48°C for 30 min, and 95°C for 5 min. For the subsequent PCR procedure, 2.5 μ l cDNA mixture was used. To perform the negative control experiment, reverse transcriptase was omitted for each sample.

The PCR was performed using real-time SYBR green technology and analyzed by an ABI 7700 sequence detector (Applied Biosystems, Foster City, CA, USA). Primer pairs for GR α , c-fos, c-jun, and GAPDH were designed to amplify 161 bp, 86 bp, 111 bp and 226 bp products, respectively. Primer sequences were as follows: GR α , 5-CAAAGAGCTAGGAAAAGC-CATTG-3 and 5-CAATACTCATGGTCTTATCCAAAATGT-3; c-fos, 5-AGGAGAATCCGAAGGGAAAAGG-3 and 5-TCCGCTTGGAGGTG-TATCAGTCA-3; c-jun, 5-CCTTCTGCGTCTTAGGCTT-3 and 5-AGTTCAACAACCGGTGCGAG-3; GAPDH, 5-GAAGGTGAAG-GTCGGAGTC-3 and 5-GAAGATGGTATGGGATTTC-3. To compare the expression level of mRNA among the subjects, the ratio of GR α , c-fos, or c-jun transcript to GAPDH transcript was calculated. Each sample was analyzed in duplicate and all PCR products were subjected to electrophoresis using 2% agarose gel to ensure that no unspecific amplicon was obtained. To further confirm the sequences, the PCR products were applied to sequencing analysis by an automated DNA sequencer (ABI 310; Applied Biosystems).

Measurement of plasma cortisol concentrations. Plasma cortisol measurement was performed by high performance liquid chromatography (HPLC) with minor modification of the procedure¹⁴. To analyze plasma samples, we added 500 μ l of 0.2 mol/l acetate buffer (pH 3.85) to 1 ml of plasma before extraction. MPSL (Sigma, Tokyo, Japan) as an internal standard was added to all samples before extraction. The plasma samples were centrifuged and GC were extracted with Sep-Pak Vac 3 ml C18 cartridges (Waters, Tokyo, Japan) preactivated with 3 ml of methanol followed by 3 ml water. After the cartridges were positioned on a 10-port vacuum elution manifold (Varian, Harbor City, CA, USA), we washed them under reduced pressure with 3 ml of each in the following order: acetone:water (25:75 by volume), water, and hexane. GC were subsequently eluted with 3 ml diethyl ether into glass tubes. The effluents were dried under nitrogen and reconstituted in 200 μ l of the mobile phase; 20 μ l of each reconstituted sample were injected into the HPLC device (Shimazu, Kyoto, Japan).

Data analysis. An unpaired T test or Mann-Whitney U test was used, when appropriate, to compare data between the 2 groups. Age matching was performed for comparison of certain indices between RA patients and controls. Pearson's correlation coefficient test was applied to investigate the correlation between the 2 factors. When IC₅₀ were applied to the Pearson test, these values were logarithmically transformed. P values less than 0.05 were regarded as statistically significant. All analyses were performed using GraphPad Prism 3.0 software (GraphPad Software, San Diego, CA, USA).

RESULTS

Comparison of GR α , c-fos, and c-jun mRNA expression in PBMC. The amount of GR α , c-fos, and c-jun mRNA in patient and control PBMC was compared. The amount of

GR α expression ranged from 0.013 to 0.686/GAPDH mRNA in the patients (n = 18) and from 0.091 to 0.277/GAPDH mRNA in controls (n = 17) after age matching. The amount of c-fos mRNA in the PBMC ranged from 0.197 to 16.60/GAPDH mRNA in patients (n = 19) and from 0.03 to 9.75/GAPDH mRNA in controls (n = 17). The amount of c-fos mRNA in PBMC from patients was significantly higher than that from controls (p = 0.001, Mann-Whitney U test; Figure 1). The amount of c-jun mRNA in the PBMC ranged from 0.004 to 0.240/GAPDH mRNA in the patients (n = 19) compared to 0.012 to 0.140/GAPDH mRNA in the controls (n = 17). There was no significant difference in the amount of GR α or c-jun mRNA expression between RA patients and controls (data not shown).

Association of GC sensitivity of RA PBMC with clinical profiles or mRNA expression of GR α , c-fos, and c-jun. In each RA patient, PSL and MPSL concentrations that would give 50% lymphocyte-mitosis inhibition (IC₅₀) *in vitro* were determined from the dose response curves. IC₅₀ for PSL and MPSL ranged from 2.7 to 1000 ng/ml and 0.1–1318 ng/ml, respectively, and thus there were large individual differences of IC₅₀ for both PSL and MPSL in the RA patients. The IC₅₀ for PSL correlated significantly with the IC₅₀ for MPSL (r = 0.85, n = 25, p < 0.0001; Figure 2). When IC₅₀ data for PSL were correlated directly with patients' RA characteristics, disease duration showed a significant correlation with PSL IC₅₀ (p = 0.035; Table 1). Other disease variables such as ESR, CRP, RF, and WBC counts did not show significant associations with PSL IC₅₀ in RA patients. Additionally, MPSL IC₅₀ in patients were found to be significantly associated with WBC counts (p = 0.004), while MPSL IC₅₀ were not found to be significantly associated

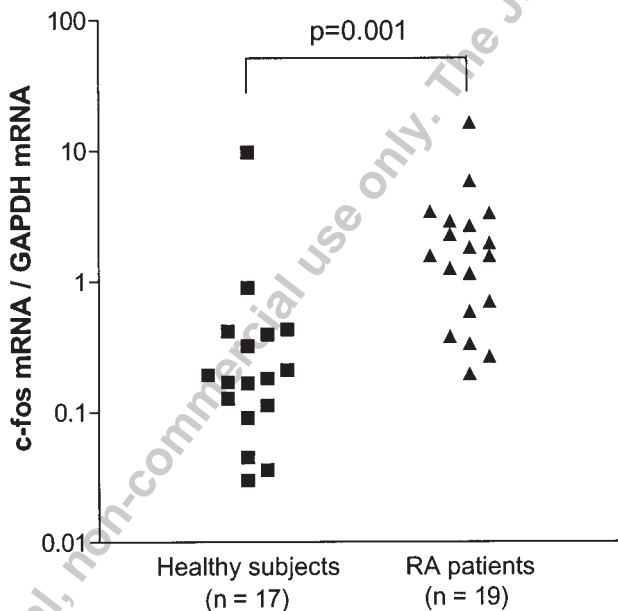


Figure 1. Comparison of relative amount of c-fos mRNA expression in PBMC between patients with RA and age matched healthy controls.

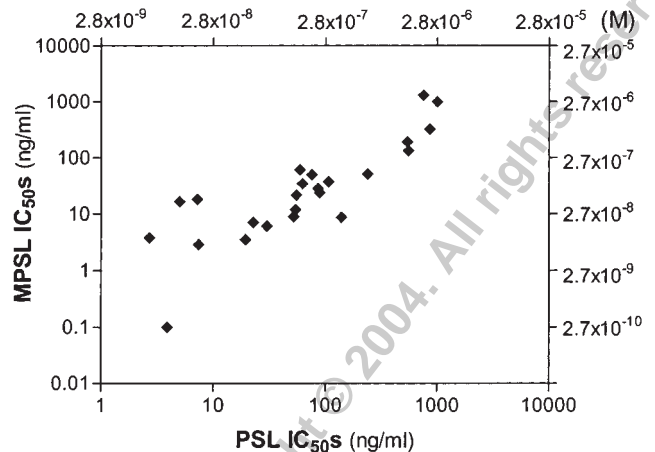


Figure 2. Correlation between IC₅₀ for PSL and MPSL in 25 patients with RA (p < 0.0001). IC₅₀ were determined from dose response curves as a GC concentration that required 50% inhibition of PBMC proliferation stimulated by concanavalin A.

with age, ESR, CRP, RF, or duration of disease. To further investigate the underlying individual differences for the lymphocyte sensitivity to GC, PSL or MPSL IC₅₀ were directly correlated with the amounts of GR α , c-fos, or c-jun transcripts. However, no significant association was observed between GR α , c-fos, or c-jun mRNA expression and GC sensitivities in PBMC (Table 1).

Relationship between GR α , c-fos, or c-jun expression and patients' characteristics. We investigated the relationship between the amounts of GR α , c-fos, or c-jun transcripts expressed in the PBMC and clinical profiles of the patients with RA. We observed a significant negative correlation between the amount of GR α mRNA expression in the PBMC and ESR in these patients (p < 0.001; Figure 3A). Similarly, CRP was also negatively correlated with the amount of GR α mRNA expression (p < 0.05; Figure 3B). We also investigated the contribution of plasma cortisol concentrations to GR α mRNA expression. Plasma cortisol concentrations deviated from 12.7 to 110.2 ng/ml (mean \pm SD 60.7 \pm 26.4 ng/ml) in these patients. However, plasma cortisol concentrations did not correlate significantly with IC₅₀ for GC (Table 1), GR α mRNA expression, or disease activity indices (data not shown).

DISCUSSION

It has been shown that lymphocyte sensitivity to GC *in vitro* determined by the inhibition of ConA-stimulated peripheral blood lymphocytes correlates with the clinical outcome of GC treatment in RA⁵. However, the molecular mechanisms underlying the individual differences of lymphocyte sensitivity to GC in RA have yet to be clarified. To investigate the factors that contribute to the development of GC insensitivity, we directly correlated PSL or MPSL IC₅₀ with the expression of mRNA for transcription factors, clinical characteristics, and laboratory data. We found that there was a

Table 1. Pearson correlation analysis between IC₅₀ of PSL or MPSL against PBMC blastogenesis and RA patient characteristics.

	Age, yrs	ESR, mm/h	CRP, mg/dl	RF, IU/ml	WBC (x 10 ³ /mm)	Duration of Disease, yrs	Relative amount (/GAPDH mRNA) of mRNA for:			Plasma Cortisol, ng/ml
							GR α	c-fos	c-jun	
PSL IC ₅₀										
N	26	25	26	25	26	26	24	25	24	25
Pearson r	-0.083	0.094	0.257	0.033	0.312	0.414	-0.037	-0.013	0.096	0.195
p	0.689	0.656	0.205	0.875	0.121	0.035	0.863	0.951	0.656	0.351
MPSL IC ₅₀										
N	25	24	25	24	25	25	23	24	23	25
Pearson r	-0.012	-0.063	0.225	0.042	0.550	0.363	0.025	0.054	0.004	0.093
p	0.954	0.771	0.281	0.846	0.004	0.075	0.912	0.804	0.987	0.657

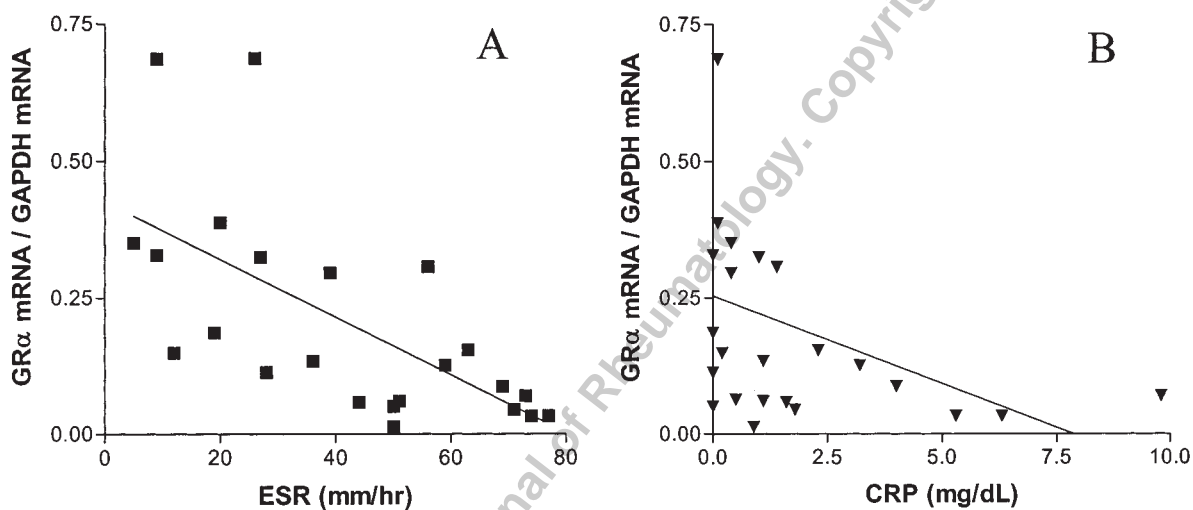


Figure 3. Significant negative correlations between relative amount of GR α mRNA expression and ESR (A) ($p < 0.001$) or CRP (B) ($p < 0.05$) in PBMC from patients with RA.

significant correlation between PSL sensitivity of PBMC and disease duration. PBMC sensitivity to MPSL also tended to be associated with disease duration, although the relationship was not statistically significant ($p = 0.075$). Reports have shown that there is no difference in disease activity or disease-related clinical indices between GC insensitive/resistant patients and GC sensitive patients with RA or inflammatory bowel diseases, suggesting that GC sensitivity is independent of disease activities^{5,15,16}. Although we did not find an association of GC sensitivity of PBMC with disease activity of RA, our observations suggest that chronic inflammation in RA may affect the GC sensitivity of peripheral lymphocytes. Thus, the data also raised the possibility that early intervention with GC treatment is more effective in the control of the disease.

Additionally, we observed significant positive correlation of MPSL IC₅₀ with WBC counts in RA patients, whereas there was no association of PSL IC₅₀ with WBC counts. Although the relationship in 25 RA patients was statistically

significant, this might not be applicable to the GC insensitive/resistant subjects, because the correlation was not significant without one patient whose MPSL IC₅₀ and WBC counts were extremely small. Nevertheless, further research will validate this association. To investigate the association of molecular characteristics with GC sensitivity of PBMC, we performed real-time RT-PCR to measure the spontaneous expression of mRNA for GR α , c-fos, and c-jun, which have been reported to be implicated in GC effects. However, no significant relationship of the expression levels of these transcripts with GC sensitivities of PBMC was observed in the patients with RA.

Although a previous report has described that the amount of GR determined by receptor binding assay in PBMC of patients with lupus nephritis correlates with the clinical outcome of GC treatment¹⁷, this is not applicable to all rheumatic diseases¹⁸. It is true that the qualitative or quantitative characteristics of GR do play a role in GC efficacy; recent studies have shown that post-receptor mechanisms

are also involved. Lane, *et al* reported that c-fos in PBMC is induced in GC-resistant asthma under basal conditions as well as the phorbol 12-myristate 13-acetate-stimulated condition as compared to GC-sensitive asthma¹⁰. Increased AP-1 interacts with GR α and inhibits the DNA binding of GR α , which also attenuates the antiinflammatory effect of GC⁶. Additionally, we have recently shown that the amount of c-fos mRNA expressed in PBMC correlates with GC sensitivity *in vitro* in asthmatic patients¹⁹. While we measured the amount of mRNA for c-fos in PBMC without stimulation in the current study, the change of expression levels of these transcripts in a stimulated condition *in vitro* might provide some clue to understanding the individual differences of GC sensitivity in RA.

One of the other candidates that may contribute to GC insensitiveness in RA is GR β , an alternative splicing isoform of GR α . GR β is unable to bind GC and is reported to be a dominant negative inhibitor of GC-GR α complex. There have been some controversial observations in terms of the dominant negative effect of GR β ²⁰⁻²², although it has been reported that GR β expression in PBMC and/or topical tissue is associated with clinical GC resistance in asthma, chronic lymphocytic leukemia, and ulcerative colitis^{16,23,24}. We also performed a qualitative assay for GR β mRNA expression; however, we found no tendency that GR β was expressed dominantly in GC-insensitive PBMC in this experiment.

Asahara, *et al* have shown that AP-1 DNA binding and c-fos mRNA expression are upregulated in RA synovial tissues and infiltrating lymphocytes⁸. They also described AP-1 DNA binding activity quantified by densitometry correlates with CRP concentrations. We found that c-fos mRNA expression in PBMC in RA patients was significantly higher than that of the healthy controls, suggesting that AP-1 at the circular level is also involved in the pathophysiology of RA. However, there was no significant correlation in the amount of c-fos transcript in PBMC with RA disease activity indices (ESR or CRP).

Our results also showed a significant negative correlation of GR α mRNA expression in PBMC with ESR or CRP levels. This observation prompted us to examine plasma cortisol concentrations at the time of blood sampling for the measurement of transcripts, as we thought this downregulation of GR α mRNA might result from a hypothalamus-pituitary-adrenal (HPA) axis anomaly influenced by the inflammatory conditions of RA. However, there was no correlation between plasma cortisol concentration and GR α expression or each inflammatory index.

Several studies have investigated the GR numbers and affinities determined by using receptor binding assay in PBMC from patients with rheumatic diseases. Schlaghecke, *et al* have shown that the number of GR in PBMC from RA patients is significantly lower than in healthy subjects²⁵. On the other hand, Gladman, *et al* have shown that the number

of GR in patients with systemic lupus erythematosus (SLE) is significantly higher compared to healthy subjects²⁶. Thus, although reports regarding the amount of GR in rheumatic diseases are contradictory, a dose-dependent GR downregulation has been observed in subjects with several rheumatic diseases including RA, SLE, and vasculitis²⁷. When it comes to the association of the number of GR with disease activity, it seems to be generally accepted that the number of GR does not correlate with inflammatory indices in RA and SLE^{25,26,28}. We have for the first time quantified the mRNA expression for GR in RA patients and demonstrated its negative correlation with the disease activity of RA. The inconsistency of our results in contrast to previous studies might be due to the different susceptibilities to change in the amounts of expression between the levels of mRNA and of proteins. It has been reported that when exogenous GC is administered, it takes 2 to 3 hours for the amount of GR mRNA to be affected, while it takes 12 to 24 hours in the case of proteins²⁷. Thus, one may speculate that the amount of mRNA is more responsive to environmental change including the circadian rhythm of cortisol than protein, and this might be one of the reasons for the discrepant observations.

Previous reports also conflict in terms of the correlation of cortisol concentration with RA disease activity expressed as ESR. Boss, *et al* have shown there is a significant positive correlation between ESR and cortisol concentration²⁹, while Schlaghecke, *et al* could not observe any correlation between baseline cortisol concentration and disease activity or GR density determined by receptor binding assay²⁵. Our report is consistent with the findings of the latter study. It has been suggested that the circadian secretion pattern of cortisol concentration is completely lost in highly active RA²⁵. It has also been observed that the salivary cortisol concentration in RA patients with ESR > 20 mm/h is persistently high in the afternoon, whereas the salivary cortisol concentration of RA patients with low ESR and healthy controls is normally suppressed in the afternoon³⁰. Thus, the circadian rhythm of cortisol concentration may be a key for examining the association of the inflammation with cortisol concentration.

In summary, we examined the implication of overexpression of transcripts for AP-1 and GR α in the pathophysiology and GC sensitivity of patients with RA. The data suggest that (1) increased c-fos mRNA expression in PBMC is related to the pathogenesis of RA; (2) chronic inflammation in RA is related to a decrease in GC sensitivity *in vitro*; and (3) changes in amounts of GR α , c-fos, and c-jun mRNA may not be related to GC sensitivity in the PBMC of patients with RA. While we found no correlation between the amounts of AP-1 or GR α mRNA and GC sensitivity in PBMC of patients with RA, the data implied that the molecular mechanism underlying GC insensitiveness in RA should be distinguished from that of asthma.

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REFERENCES

1. Corrigan CJ, Brown PH, Barnes NC, et al. Glucocorticoid resistance in chronic asthma. Glucocorticoid pharmacokinetics, glucocorticoid receptor characteristics, and inhibition of peripheral blood T cell proliferation by glucocorticoids in vitro. *Am Rev Respir Dis* 1991;144:1016-25.
2. Corrigan CJ, Brown PH, Barnes NC, Tsai JJ, Frew AJ, Kay AB. Glucocorticoid resistance in chronic asthma. Peripheral blood T lymphocyte activation and comparison of the T lymphocyte inhibitory effects of glucocorticoids and cyclosporin A. *Am Rev Respir Dis* 1991;144:1026-32.
3. Hirano T, Oka K, Takeuchi H, et al. Clinical significance of glucocorticoid pharmacodynamics assessed by antilymphocyte action in kidney transplantation. Marked difference between prednisolone and methylprednisolone. *Transplantation* 1994;57:1341-8.
4. Hirano T, Oka K, Takeuchi H, et al. Immunosuppressant pharmacodynamics on lymphocytes from healthy subjects and patients with chronic renal failure, nephrosis, and psoriasis: possible implications for individual therapeutic efficacy. *Clin Pharmacol Ther* 1997;62:652-64.
5. Kirkham BW, Corkill MM, Davison SC, Panayi GS. Response to glucocorticoid treatment in rheumatoid arthritis: in vitro cell mediated immune assay predicts in vivo responses. *J Rheumatol* 1991;18:821-5.
6. Barnes PJ. Anti-inflammatory actions of glucocorticoids: molecular mechanisms. *Clin Sci (Colch)* 1998;94:557-72.
7. Sirum-Connolly K, Brinckerhoff CE. Interleukin-1 or phorbol induction of the stromelysin promoter requires an element that cooperates with AP-1. *Nucl Acids Res* 1991;19:335-41.
8. Asahara H, Fujisawa K, Kobata T, et al. Direct evidence of high DNA binding activity of transcription factor AP-1 in rheumatoid arthritis synovium. *Arthritis Rheum* 1997;40:912-8.
9. Adcock IM, Lane SJ, Brown CR, Lee TH, Barnes PJ. Abnormal glucocorticoid receptor-activator protein 1 interaction in steroid-resistant asthma. *J Exp Med* 1995;182:1951-8.
10. Lane SJ, Adcock IM, Richards D, Hawrylowicz C, Barnes PJ, Lee TH. Corticosteroid-resistant bronchial asthma is associated with increased c-fos expression in monocytes and T lymphocytes. *J Clin Invest* 1998;102:2156-64.
11. Shimizu K, Kawasaki H, Morisawa T, et al. Spontaneous and cytokine regulated c-fos gene expression in rheumatoid synovial cells: resistance to cytokine stimulation when the c-fos gene is overexpressed. *Ann Rheum Dis* 2000;59:636-40.
12. Hirano T, Oka K, Umezawa Y, Hirata M, Ohi T, Koga M. Individual pharmacodynamics assessed by antilymphocyte action predicts clinical cyclosporine efficacy in psoriasis. *Clin Pharmacol Ther* 1998;63:465-70.
13. Hirano T, Akashi T, Keira T, Oka K, Ihoya N, Yoshida M. Clinical impact of cyclosporine cellular pharmacodynamics in minimal change nephrotic syndrome. *Clin Pharmacol Ther* 2000;68:532-40.
14. McWhinney BC, Ward G, Hickman PE. Improved HPLC method for simultaneous analysis of cortisol, 11-deoxycortisol, prednisolone, methylprednisolone, and dexamethasone in serum and urine. *Clin Chem* 1996;42:979-81.
15. Hearing SD, Norman M, Probert CS, Haslam N, Dayan CM. Predicting therapeutic outcome in severe ulcerative colitis by measuring in vitro steroid sensitivity of proliferating peripheral blood lymphocytes. *Gut* 1999;45:382-8.
16. Honda M, Orii F, Ayabe T, et al. Expression of glucocorticoid receptor beta in lymphocytes of patients with glucocorticoid-resistant ulcerative colitis. *Gastroenterology* 2000;118:859-66.
17. Tanaka H, Akama H, Ichikawa Y, Makino I, Homma M. Glucocorticoid receptor in patients with lupus nephritis: relationship between receptor levels in mononuclear leukocytes and effect of glucocorticoid therapy. *J Rheumatol* 1992;19:878-83.
18. Schlaghecke R, Beuscher D, Kornely E, Specker C. Effects of glucocorticoids in rheumatoid arthritis. Diminished glucocorticoid receptors do not result in glucocorticoid resistance. *Arthritis Rheum* 1994;37:1127-31.
19. Takahashi E, Onda K, Hirano T, et al. Expression of c-fos, rather than c-jun or glucocorticoid-receptor mRNA, correlates with decreased glucocorticoid response of peripheral blood mononuclear cells in asthma. *Int Immunopharmacol* 2002;2:1419-27.
20. Bamberger CM, Bamberger AM, de Castro M, Chrousos GP. Glucocorticoid receptor beta, a potential endogenous inhibitor of glucocorticoid action in humans. *J Clin Invest* 1995;95:2435-41.
21. Hecht K, Carlstedt-Duke J, Stierna P, Gustafsson J, Bronnegard M, Wikstrom AC. Evidence that the beta-isoform of the human glucocorticoid receptor does not act as a physiologically significant repressor. *J Biol Chem* 1997;272:26659-64.
22. Oakley RH, Jewell CM, Yudit MR, Bofetiado DM, Cidlowski JA. The dominant negative activity of the human glucocorticoid receptor beta isoform. Specificity and mechanisms of action. *J Biol Chem* 1999;274:27857-66.
23. Hamid QA, Wenzel SE, Hauk PJ, et al. Increased glucocorticoid receptor beta in airway cells of glucocorticoid-insensitive asthma. *Am J Respir Crit Care Med* 1999;159:1600-4.
24. Shahidi H, Vottero A, Stratakis CA, et al. Imbalanced expression of the glucocorticoid receptor isoforms in cultured lymphocytes from a patient with systemic glucocorticoid resistance and chronic lymphocytic leukemia. *Biochem Biophys Res Commun* 1999;254:559-65.
25. Schlaghecke R, Kornely E, Wollenhaupt J, Specker C. Glucocorticoid receptors in rheumatoid arthritis. *Arthritis Rheum* 1992;35:740-4.
26. Gladman DD, Urowitz MB, Doris F, Lewandowski K, Anhorn K. Glucocorticoid receptors in systemic lupus erythematosus. *J Rheumatol* 1991;18:681-4.
27. Sanden S, Tripmacher R, Weltrich R, et al. Glucocorticoid dose dependent downregulation of glucocorticoid receptors in patients with rheumatic diseases. *J Rheumatol* 2000;27:1265-70.
28. van Everdingen AA, Huisman AM, Wenting MJ, van Reesema S, Jacobs JW, Bijlsma JW. Down regulation of glucocorticoid receptors in early-diagnosed rheumatoid arthritis. *Clin Exp Rheumatol* 2002;20:463-8.
29. Boss B, Neeck G. Correlation of IL-6 with the classical humoral disease activity parameters ESR and CRP and with serum cortisol, reflecting the activity of the HPA axis in active rheumatoid arthritis. *Z Rheumatol* 2000;59:62-4.
30. Dekkers JC, Geenen R, Godaert GL, van Doornen LJ, Bijlsma JW. Diurnal rhythm of salivary cortisol levels in patients with recent-onset rheumatoid arthritis. *Arthritis Rheum* 2000;43:465-7.